CORE BIOPSY OF THE BREAST
Patient Record

Date:	Referring Physician:	
Patient:	DOB:	MRN#:
Allergies:		
Mammography Findings:		
Procedure Explained to Patient by:	Consent Signed: YES NO	
Area Anesthetized With:		
Time Biopsy Collected:	Radiologist:	
Number of Specimens:		
Was Clip Deployed: YES NO		
Any complications:		
Post-Care Explained to Patient: YES NO		
Copy of Post-Care Instructions Given to Patient: YES NO		
Follow up call Date:	Time:	By:
Comments:		

________________________ M.D.
Physician Signature

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Technologist Signature